Comments of the Virginia Health Care Association

Development of a Blue Print for the Integration of Acute and Long Term Care
Virginia Department of Medical Assistance Services

October 11, 2006

On behalf of our 233 nursing facility members, the Virginia Health Care Association (VHCA) appreciates the opportunity to comment on efforts now underway by the Department of Medical Assistance Services (DMAS) to respond to a directive from Governor Kaine to develop a plan to serve as a blueprint for moving towards an integrated, acute and long term care delivery system.

We applaud the desire on the part of advocates, providers and state policymakers to explore options for the development of a system of long term care delivery which spans a continuum of coordinated services that does not exist today. We are all aware that unless changed, the model for today's long term care delivery which focuses primarily on facility-based care and care provided under a variety of home and community waiver programs will likely falter as baby boomers age and begin to require long term care services. We support efforts to develop new programs and alternatives that will delay the need for seniors to utilize the costly services which comprise the majority of today's care options.

While we support and encourage the exploration of new options and alternatives for the delivery of long term care services, we also caution policymakers against pursuing "knee-jerk" and over-simplified strategies for addressing Virginia's Medicaid-funded long term care needs. A viewpoint expressed by many today is that aggressive expansion of home and community-based long term care services should serve as the foundation for a new model for more compassionate and less costly care.

It is hard to imagine individuals in need of long term care who would not desire to be taken care of in their own home – and this option should be the preferred care setting when appropriate. But defining "appropriate" is not an easy task. Issues including beneficiary health status, the existence of quality of care oversight, the availability of both paid as well as unpaid or informal caregivers, and the coordination of services in a cost-effective approach must all be considered before making decisions regarding appropriate care settings.

VHCA suggests that all groups including advocates, payors and providers need to do a better job of identifying and documenting what works and what does not work within the existing models of providing long term care services. The availability of unpaid informal caregivers necessary for the successful care of nursing facility eligible individuals within home and community-based care programs is in short supply. Today's dual wage earner economic environment represents a dramatic departure from family structures of just 20-30 years ago where there was often a daughter, son, or grandchild available to assist someone in the home with his or her long term care needs. Additionally, health care providers across the spectrum compete for qualified nursing staff – a problem likely to grow as baby boomers age and start to access long term care services.

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Despite efforts by some to negatively characterize the care provided in nursing facilities, Virginia's nursing homes provide high-quality, cost-effective care to nearly 18,000 Medicaid residents each and every day. This care is delivered around the clock by dedicated caregivers in an environment designed to ensure the safety and satisfaction of both residents and staff. Indeed, a 2005 survey of 111 Virginia nursing homes conducted by an independent research and quality improvement organization found that 80% of more than 3,600 family members surveyed gave their facility either an excellent or good rating, and indicated they would recommend it to others as a place for a loved one to receive care.

In an effort to better understand the potential for and cost of transitioning Virginia nursing facility residents to home and community-based care services, VHCA commissioned an independent study to answer the question, "Could a significant number of Virginia Medicaid nursing facility residents be cared for at an equal or reduced expense to the state in their home or other community-based care option?"

To answer the question, the study which was recently completed and will be made available prior to October 31st, reviewed the Minimum Data Set (MDS) records of over 73,000 unique Virginia nursing facility residents during 2005. The study focused on almost 18,000 Medicaid nursing facility residents that had a full MDS assessment conducted in 2005. The study compares real costs in various settings and determines the number of current nursing facility residents that might be taken care of in a home or community-based setting.

Major findings of the study include: (1) only about 1.3% of all nursing facility residents have over a 50% likelihood of discharge from a nursing facility due to their need for intensive health care and available assistance at home or in the community; (2) the availability of an informal caregiver is the single most important factor in determining the probability for discharge back to the community; (3) home and community-based services for nearly 99% of 2005 Virginia Medicaid nursing facility residents would be two to three times more expensive than nursing home care; and (4) home and community-based services are less costly than facility-based care *only* when the state is not paying for bed and board *and* when informal/family caregiver support exists for individuals with generally less severe physical and cognitive conditions.

The study also reveals the actual cost of care for Medicaid long term care to the Commonwealth of Virginia's General Fund to be only $50 per day for the average nursing home, $33 per day for the average Assisted Living Auxiliary Grant recipient and $40 per day for participants in the existing pre-PACE program. Other community programs varied greatly in their costs. These amounts take into consideration the impact of "patient pay" offsets which serve to lower the actual state support expenditure by requiring that Medicaid beneficiaries assign income from sources such as social security to cover the cost of their care and the fact that 50% of Medicaid outlays in Virginia come from Federal sources.

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Key findings and observations of the study are:

- There were more than 330,000 MDS assessments for over 73,000 unique Virginia nursing facility residents during 2005. There were approximately 18,000 unique Medicaid residents that had a full MDS assessment conducted. Other residents were primarily private pay or short-term Medicare funded residents.

- Of these 18,000 unique Medicaid residents, 915 were discharged back to a home setting or assisted living facility in 2005. The study found that the 915 discharged residents were generally younger, had shorter stays, had significantly fewer physical and mental problems, and generally had someone in the community to assist in their care.

- Based on a statistical analysis of these 915 Medicaid NF residents, only about 214 or 1.3 percent of the remaining 17,000 Medicaid NF residents, could expect to be discharged to a community-based setting at an equivalent or lower cost.

- The study found that while a number of factors are important to discharge status – including activities of daily living (ADL) status, cognitive acuity, and the use of therapy – the availability of an informal unpaid caregiver is the single most important factor in determining the probability for discharge back to the community. In other words, discharge is highly correlated with informal caregiver availability and less acute diagnosis.

- Using the MDS database, the study constructed eight hypothetical individual profiles for purposes of comparing the specific costs of community-based care with the costs of providing facility-based care. The eight profiles were composed of four with a high probability (greater than 50%) for discharge (1.3% of all residents) and four with a low probability for discharge (or those 98.7% of all residents with a less than 50% probability for discharge).

- The study found that the cost of home and community-based services for almost 99% of the 2005 Virginia Medicaid nursing facility residents would be two to three times more expensive than nursing home care. These findings support the argument that Virginia nursing facilities are the care centers of last resort, and are being appropriately utilized to provide high-quality, cost effective long term care nursing services to Medicaid recipients with serious medical or cognitive health conditions.

- The study indicates that home and community-based services are less costly to Virginia than facility-based care ***only*** when bed and board are self-provided ***and*** when informal/family caregiver support exists for individuals with generally less severe physical and cognitive conditions.

Comments of the Virginia Health Care Association

We recognize that the Olmstead decision, federal initiatives such as "Money Follows the Person" and "Real Choice Systems Change Grants" demonstrate a desire for people needing Medicaid long term care services to be given the option of Medicaid sponsored care in community settings. **If additional Medicaid long term care funds are to be allocated to home and community-based care, it should be done to expand options for Medicaid recipients and not as a cost saving strategy for Medicaid.** Given the strict Medicaid nursing home admission criteria in place in Virginia, the study confirms the fact that few nursing home eligible Medicaid recipients can be cared for more effectively, efficiently or inexpensively in other settings.

As the baby boomers age, the number of people needing long term care services will dictate an increase in the overall costs to society. All levels of long term care will be necessary to keep up with the demand for services. Innovative policies will be needed to care for the frail and elderly in the most efficient and cost-effective setting. The Virginia Health Care Association stands committed to work with other providers of long term care services and with DMAS to provide the most appropriate care for Virginia's frail elderly and disabled citizens.